

Amyotrophic Lateral Sclerosis Disease Registry
Massachusetts Department of Public Health
Report Form

Date of Report: ____/____/____

Reporting Information:

Name of person completing this form:

Phone: _____

E-mail: _____

In the future, please contact the following person for these requests:

Please check the appropriate box:

☐ **Yes** - I evaluated or diagnosed ALS cases between **January 1, 2016 and December 31, 2016** (*Please list patients and mail to the address provided*)

☐ **Yes** - As a representative of my department, the following patients were evaluated for or diagnosed with ALS between **January 1, 2016 and December 31, 2016** (*Please list patients and mail to the address provided*)

☐ **No*** - I or my department did not evaluate or diagnose ALS cases between **January 1, 2016 and December 31, 2016** (*If selecting this option, report form may be faxed to 617-624-5778*)

Patient Information:

First Name	Last Name	Medical Record Number	DOB

*Please mail this form **as soon as possible** to:*
MDPH-Bureau of Environmental Health
Vanna Abille, MPH
250 Washington Street, 7th Floor
Boston, MA 02108
Phone: (617) 624-5757